DATA IDENTIFIER	**New Jersey Department of Health and Senior Services** ***CONFIDENTIAL* SEXUALLY TRANSMITTED DISEASE REPORT**	DATE OF REPORT

PATIENT NAME *(Last, First, Middle/Maiden)*	PHONE NUMBER	PATIENT STREET ADDRESS

AGE	DATE OF BIRTH	PREGNANT	SEX	RACE	ETHNICITY	CITY/TOWN	ZIP CODE
		☐ Yes ☐ No	☐ M ☐ F	☐ White ☐ Am. Indian ☐ Black ☐ Asian/Pac.Is. ☐ Other	☐ Hispanic ☐ Non-Hispanic		

STD DISEASE CODES

710 Primary Syphilis (lesion present)
720 Secondary Syphilis (rash present)
730 Early Latent Syphilis (<1 yr. duration)
745 Late Latent Syphilis (>1 yr. or unknown duration)
750 Late Syphilis with Symptomatic Manifestations
760 Neuro Syphilis
100 Chancroid
200 Chlamydia
300 Gonorrhea
500 Granuloma Inguinale
600 Lymphogranuloma Venereum

PLEASE WRITE IN CODES FOR DISEASE(S) YOU ARE REPORTING FOR THIS PATIENT:

☐ ☐ ☐ ☐ ☐ ☐

PROVIDER/ PHYSICIAN: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE: _____

FOR NJDHSS USE ONLY

FIELD UNIT CASE #:

PROVIDER TYPE CODE #:

LABORATORY TEST

Laboratory Name:

Date	Test	Reactive	Titer	Non-Reactive
	RPR			
	VDRL			
	FTA-ABS			
	TP-PA			

Date	Disease	Result	Test Type	Specimen Site
	CHLAMYDIA			
	GONORRHEA			

TREATMENT ADMINISTERED

Date Treatment Started: _____

☐ Benzathine PCN, 2.4 mu IM x _____ weekly doses
☐ Ceftriaxone (Rocephin®), 125 mg IM
☐ Doxycycline 100 mg p.o. bid x _____ days
☐ Azithromycin 1 gm
☐ Other:
☐ NO TREATMENT ADMINISTERED
(Explain in *Comments*)

PLEASE MAIL REPORT IN SEALED ENVELOPE TO:
New Jersey Department of Health and Senior Services
Sexually Transmitted Disease Program
PO Box 369, Trenton, NJ 08625-0369

COMMENTS: _____

STD-11
AUG 06

For Information: **(609) 588-7526**
After Hours: **(609) 392-2020**
Fax: **(609) 588-7462**

Do you need a supply of: ☐ Report Forms ☐ Pre-Addressed Envelopes